

Easter Seals Colorado Summit Day Camp Medical Form

(Camper's Name)

(Camp Session)

Please return this form **with physician's signature within one week of camp session** to:

Easter Seals Summit Day Camp

PO Box 1247 Frisco, CO 80443

Or Summit@eastersealscolorado.org

Please attach a copy of Insurance/Medicaid/Medicare card. Application will be returned if incomplete.

Medical History

1. Are the applicant's immunization records up-to-date and complete? Yes No
If applicant is under 18 years old, please attach a copy of records.

2. Date of last tetanus shot _____ (Mandatory Information)

3. Has there been any recent exposure to a contagious disease? Yes No
 - a. If yes, please explain

4. How would you assess the applicant's current health? Good Fair Poor

5. List any chronic health problems (e.g. asthma, pressure sores, cough, constipation) and treatments of which the medical staff should be aware:

6. Is the applicant a carrier of Hepatitis B or has he/she been exposed to Hepatitis B? Yes No
 - a. If yes, was a lab test conducted to determine the presence of antibodies? Yes No
 - b. Were antibodies present? Yes No **Physician's Initials** _____

7. Is the applicant a carrier of any other infectious or contagious condition? Yes No
 - a. If yes, please explain:

8. Does the applicant have any known allergies? Yes No
 - a. If yes, please describe:

9. Does the applicant have seizures? Yes No
 - a. **If yes, please answer the following:**
Current status (i.e. active, controlled): _____

 - b. Type of seizure: How often: _____

Camper Name: _____

Easter Seals Colorado Summit Camper Medical Form (Continued)

Medications: List all medications, vitamins and supplements currently taken by the applicant.
Please continue list of medications, vitamins and supplements on the back of this form.

<u>Med. Name</u>	<u>Dose</u>	<u>Route</u>	<u>Frequency</u>	<u>Times Given</u>	<u>Reason Prescribed</u>
1) _____					
2) _____					
3) _____					
4) _____					

Please describe how the applicant best takes the medication(s)? (ie, with water, pudding, etc.)

**All medications must be prepackaged in a medication cassette by a pharmacist or caregiver.
You must include the original bottles and at least one pill in original bottles.**

Restrictions:

- Has the applicant been hospitalized or treated in an emergency room recently? Yes No
 If yes, please explain: _____

- Are there any physical conditions, past operations or injuries which should restrict camp activity? Yes No
 If yes, please explain and list any restricted area: _____

- Please list any dietary restrictions: _____

Physician's initials _____

- Does the applicant require a night attendant at home? Yes No
 If yes, the applicant must bring the night attendant with him/her to camp and prior arrangements must be made ahead of time for the applicant's night attendant.

- Pulse Oxide Range _____ to _____ **Physician's Initials** _____

Camper Name: _____

